such as 'powerless, information poor patients' and 'powerful, information rich doctors.'

Of course, doctors are information rich in our sphere of practice. It is what we have spent our lives learning and practising, not for our own benefit, but to the greater end of putting our knowledge to the service of patients. If we were not information rich we would be without use. The patient may as well consult their plumber or hairdresser. The great joy of sharing information freely is that both parties to the transaction end up richer, and neither can be poorer as a result of the sharing. Ironically, it is also more respectful than pure patient centeredness, as it acknowledges the agency of both participants in the consultation.

The world is primary, and as part of it, and made of the same stuff as it, so are we. Our relationship to the world is a second order issue and our representations of this relationship (thoughts/feelings/ perceptions/ decisions/actions) are beyond this. Words are tools we use to describe these relationships but they have no meaning except insofar as they relate us, and others, to the world we experience. Words are representations of meaning, not meaning itself.

And so we arrive. The map is not the territory. We cannot have the map or the territory, we must necessarily have both together, and be aware of the relationship between them. We must not take the one for the other, for that way insanity and confusion lie. We all have our maps and they all have some accuracy and some inaccuracy. The criterion for truth is correspondence and correlation between the map and the world, and this restores great objectivity to our subjectivity. There is more accuracy to our subjective impressions of the world than we realise.

And delusions are still delusions, as the map-territory correspondence is recognised as being broken in delusions.

My conclusion is that there can be much accuracy and much inaccuracy in both subjective and objective viewpoints. The ultimate reality test is correspondence with the world. To the extent that our views match the reality we, and others, encounter, they are accurate and to the extent they mismatch, they are inaccurate.

But there is more accuracy, and more valid, if not readily verifiable, information, in subjective viewpoints than modern science cares to admit. To return to Jane Austen, 'a single man in possession of a good fortune, must be in want of a wife.' Objectivity and subjectivity are married together in our search for knowledge of the world, and try as we might, what God has joined we should not struggle to put asunder.

Peter Davies

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Neville Goodman

COGS IN A MACHINE

Once upon a time we were staff, then we became personnel. Latterly we have been human resources, an expression completely lacking in humanity. The NHS has trouble with HR directors, in the sense that they don't seem to stay long. A little while ago, there wasn't a permanent HR director in any of our local Trusts. Things are better now, although ours has become 'Director of Organisation, People and Performance'. Our whole Trust is an organisation, so what does this mean? Is he organising just the people, or the whole Organisation? Should we read something sinister into his direction of performance? Why has the job title changed from Director of Personnel, which, like 'dustman', is a self-evident description of the job, to Director of Organisation, People and Performance, which, like sanitation collection operative, is recognised by everybody as just being a dustman?

Our Trust is anxious to become a Foundation Trust, and is planning a super new PFI hospital. There are great things ahead (we are told). I hope this is true, though not because I want a better place to work, because I shall be long retired before it opens its doors to patients. This enthusiasm, which I cannot fault, has spawned a flurry of e-mail cascading down from the Press Office about our future, and which features heavily the Trust's 'Big Five' objectives. Four of these are to improve patient safety, to aim for no waits for treatment, to make progress towards our new hospital, and to achieve Foundation status.

No contention there, and who could argue with the remaining objective: to become a great place to work? Eager to learn more, I read further, to the list detailing how this would happen. The first item read, 'Organisation Development and Workforce Strategy developed, incorporating core values and key workforce metrics'. I do not understand what this means. It is not obvious to me how this will make the Trust a great place to work in the way that, say, having excellent crèche facilities would do, and in a way that every member of staff would understand. Reading further, staff contribution will be maximised by 'learning-needs analysis mapped based upon individual, team, job and organisational needs for the future'. If this means more than, 'We will tell you what you are going to do', I'd like to know how.

My polite request for some explanation of how all this will be so good for us was eventually acknowledged and passed on to our Director of Organisation, People and Performance, who so far has not replied.